CARDIOLOGY MEDICAL REPORT
P-142C REV. 5-2001

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MEDICAL REVIEW DIVISION
On The Web At http:// dmvct.org

TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510

PATIENT'S NAME	DATE OF BIRTH	TELEPHONE NO.

ADDRESS	WHEN WAS PATIENT LAST EXAMINED BY YOU?

HISTORY OF ANY DISORDER RELEVANT TO SAFE OPERATION OF A MOTOR VEHICLE *(Very Brief Outline)*

TECHNICAL REPORT(S) (VIS: ECHO, SCAN, HOLTER, EKG, CATH) WITH FINDINGS RELEVANT TO DRIVING A MOTOR VEHICLE SAFELY

DATE	TEST	RESULT
1.		
2.		
3.		

LAST EPISODE OF ALTERED CIRCULATORY STABILITY ENOUGH TO INTERFERE WITH SAFE DRIVING.	MONTH	YEAR	TYPE

MEDICATIONS (RELEVANT TO DRIVING)

TYPE	DOSE
TYPE	DOSE
TYPE	DOSE

DO YOU BELIEVE PATIENT UNDERSTANDS THE SIGNIFICANCE OF HIS/HER DISORDER? ☐ YES ☐ NO	DO YOU BELIEVE PATIENT IS COMPLIANT AS REGARDS PRESCRIBED MEDICATIONS? ☐ YES ☐ NO

OF WHAT OTHER RELEVANT MEDICAL, SURGICAL, OR PSYCHIATRIC HISTORY ARE YOU AWARE? *(Use additional sheet of paper if necessary)*

DO YOU HAVE REASON TO SUSPECT THE PATIENT ABUSES ALCOHOL OR MEDICATIONS (INCLUDING ILLICIT DRUGS)? ☐ YES ☐ NO

IF YOUR REPLY IS AFFIRMATIVE, PLEASE ELABORATE BRIEFLY.

DOES THE PATIENT ACKNOWLEDGE EVER HAVING HAD ANY MOTOR VEHICLE ACCIDENTS? ☐ YES ☐ NO

TO YOUR KNOWLEDGE, HAS THE PATIENT EVER HAD A LICENSE DENIED OR REVOKED? ☐ YES ☐ NO	YEAR	STATE	REASON

ABNORMALITIES ON CARDIAC EXAMINATION INCLUDING MENTAL STATUS

WHAT IS YOUR OPINION ABOUT THIS PERSON'S ABILITY TO OPERATE A MOTOR VEHICLE SAFELY? UNDER WHAT CIRCUMSTANCES MAY HE/SHE DO SO? *(Please elaborate)*

DOES THIS PATIENT HAVE A DETERIORATING CONDITION? ☐ YES ☐ NO **IF YES, SPECIFY CONDITION AND INDICATE HOW OFTEN HE/SHE SHOULD BE RE-EXAMINED?**

PHYSICIAN'S NAME *(Please Print or Type)*	OFFICE ADDRESS *(Include Zip Code)*

TELEPHONE NO.	PHYSICIAN'S LICENSE NO.	PHYSICIAN'S SPECIALTY

PHYSICIAN'S SIGNATURE	DATE REPORT COMPLETED
X	